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ABSTRACT

Depression is the single most widespread mental health problem facing the elderly, with pharmacotherapy the most frequent standard treatment modality for these patients. A psycho-therapeutic alternative to pharmacotherapy is Life Enhancement Counseling, a counseling approach matching therapeutic techniques to client characteristics and providing an age-appropriate and culturally sensitive treatment model for alleviating depression. Elderly subjects (N=100), mostly Hispanic Americans, completed two sets of measures of functioning pre- and post-therapy. Outcome analysis indicated that significant improvement in functioning occured along all dimensions of psychosocial functioning. Results showed that, among this Cuban-American sample, outcome was independent of client variables: two treatment variables, extent of Life Enhancement counseling and medication, were signifi- cantly predictive of treatment outcome. In many cases, the difficulties of the elderly were amenable to psychosocial intervention both with and without pharmacotherapy. These results support the concept that many psychological difficulties of the elderly are potentially reversible rather than inevitable consequences of aging. (Author/NRB)

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Life Enhancement Counseling:

Treating Depression Among Hispanic Elders

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Life Enhancement Counseling:

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There are currently about 22 million elders in the United States, making up approximately 10% of the total population. The number of elders is projected to increase to nearly 16% or 42 million by the year 2025 (Ban, 1978). It has been estimated that over 25% of older citizens suffer from significant mental health problems, and over 25% of all suicides reported are committed by the elderly (Carter, 1979). Moreover, among the elderly the incidence of mental health disorders is related to age, with the highest rates of first admissions to mental hospitals found in the oldest cohort of elders (Kramer, Taube and Starr, 1968). Thus, the mental health needs of the elderly population, which are already disproportionately high, can be expected to increase dramatically in the coming years as the numbers of elders increase.

Among the elderly, there are two major mental health problems, senile dementia and depression. Senile dementia is the most terrifying mental health problem of the elderly, reported to be the fourth leading cause of death (Cohen, 1979). Depression, on the other hand, is the single most widespread mental health hazard affecting elders. It is considered to be a major factor in the very high levels of suicides among elders. In view of the dire mental health needs of elders, it is unfortunate that the necessary support and mental health services are alarmingly unavailable. For instance, only 2% of all the patients seeing private psychiatrists are elders, and less than 3% of the budget of the National Institute of Mental Health has been spent on the plight of older persons (Carter, 1979). Although there are many reasons for this

state of affairs, one important reason has been the dearth of appropriate treatment procedures. This dearth is rooted in a lack of understanding of the ways in which elders function and the unavailability of creative strategies for turning elders' characteristics, typically perceived as weaknessnes, into strengths. Unfortunately, because the many psychological problems of the elderly are viewed as inevitable aspects of growing old rather than as reversible symptoms of psychosocial or interpersonal problems, pharmacotherapy is frequently the standard treatment modality with depressed elders. As this article will attempt to demonstrate, many of the psychological problems of the elderly are ameanable to psychosocial interventions. Moreover, in many cases antidepressant medication is contra-indicated because of chronic medical illnessnes, pointing to another important reason for nonpharmacological treatment alternatives. Surprisingly little systematic research has been done on the evaluation of psychotherapeutic alternatives to pharmacotherapy for the treatment of depression among elders (Jarvik, 1976). For example, two recent issues of the American Journal of Psychotherapy (Vol. 32, I & II) focused on therapeutic approaches to the treatment of depression. Of the thirteen articles dealing with the treatment of depression, only one discussed the treatment of depressed geriatric patients, and that article (Ban, 1978) reviewed pharmacological treatments.

Life Enhancement Counseling (Szapocznik, Santisteban, Kurtines, Hervis and Spencer, in press) represents an attempt to offer an alternative model for conceptualizing counseling for the elderly by matching therapeutic techniques to client characteristics. The demonstration project that served as the basis for the development of Life Enhancement Counseling was supported by the

Administration on Aging and was carried out at the Spanish Family Guidance Center in Miami, Florida. Life Enhancement Counseling builds on elders' strengths and natural proclivities, while utilizing environmental resources to buttress elders' functioning. It has been developed specifically for the treatment of one of the most pervasive mental health problems confronting the elderly: a problem that is typically diagnosed as depression, but conceptualized by this approach as a loss of meaning and purpose in life. As an intervention approach, Life Enhancement Counseling has been designed to provide a replicable intervention methodology, with clearly delineated steps and procedures.

Within the nonpharmacological approaches, the concept of matching treatment modalities with client variables has been discussed frequently by mental health treatment methodologists and has received widespread endorsement (Bergin, 1971; Kiesler, 1971; Paul, 1969; Sloane, Staples, Criston, Yorkston and Whipple, 1974). The proper procedure for matching clients and treatment methods, however, has been a matter of debate. There are those who advocate that alternative treatment methods can be developed to match client characteristics (e.g. Hunt, 1960; Lorion, 1974; Magaro, 1969), and those who argue that traditional psychotherapy can be effectively extended to different client populations via special techniques that facilitate a therapeutic relationship (e.g. Gould, 1967; Heitler, 1976; Orne and Wender, 1968; Terestman, Miller and Weber, 1974).

The research reported here is based on the premise that psychosocial services should take into consideration a population's unique characteristics and should address the particular mental health hazards confronting the group. We have argued elsewhere (Szapocznik, Scopetta and King, 1978; Szapocznik,

Scopetta, Aranalde and Kurtines, 1978) that cultural background constitutes an important client characteristics that must be considered in the development of treatment modalities. Culturally sensitive treatment is a treatment mode built on a set of therapeutic assumptions that complements the patients' basic value structure. Since most of the elders involved in the research reported here were Cuban or Hispanic, there were two special sets of unique characteristics that had to be taken into consideration in the development of Life Enhancement Counseling. One was related to ethnicity and cultural background, and the other was related to advanced age.

Cultural Sensitivity. Clinical experience and previous research (Szapocznik, et. al., 1978ab) suggests that Cuban and Anglo Americans differ along several important dimensions. Some of the most basic differences between these groups can be understood in terms of their value orientation (Kluckhohn and Strodtbeck, 1961). Relative to Anglo Americans, Cuban immigrants tended to value lineality, adhere to a present time orientation, and lack the orientation to attempt to exercise control over natural forces and environmental conditions (Santisteban, 1975; Szapocznik, Scopetta, Kurtines and Aranalde, 1978). The Life Enhancement Counseling model was designed to be culturally sensitive to these basic value orientations.

Age Appropriateness. Central to the therapeutic strategies chosen for inclusion in Life Enhancement Counseling is making therapeutic use of specific characteristics of elders. For example, one characteristic of elders is their tendancy to reminisce about their life experiences (Butler, 1961). Since reminiscence occurs spontaneously and is ego-syntonic to elders it is readily available for therapeutic strategy which has been widely used with elders

(Butler, 1961; Lewis and Butler, 1974). Because elders tend to be plagued by social problems, the model was also designed to allow the therapist access to the elders' social environment. An ecological approach to conceiving of problems and their solutions then, seems particularly appropriate with elders: Isolation, for example, is more typical among elders than other age groups because of their lesser physical mobility and their difficulties in using transportation; and, isolation is frequently ameanable to environmental interventions.

This paper reports data on the effectiveness of Life Enhancement Counseling.

METHOD

Subjects

A total of 141 elders contacted the Center seeking psychosocial services during the course of the demonstration project. Of this number, twenty-two persons dropped out after one session; eight became inaccessible after they had engaged in treatment (five moved away and three died); and eleven were still active when the project ended and were transferred to the local community mental health center and did not receive post tests. Complete data (both pre and post test) were thus available on 100 elders. This group constituted the basic sample used for the analyses reported below.

For purposes of analysis, the 100 cases were further divided into three samples. Sample 1 consisted of nineteen clients identified by the staff, using a procedure described below, as inappropriate for Life Enhancement Counseling. These nineteen individuals had special problems such as organic brain dysfunction which made it necessary to limit their treatment to the

rearrangement of their environmental situation and some supportive therapy. Sample 2 consisted of fifteen elders identified as non-Cuban Hispanics or Anglos. Sample 3 consisted of 66 Cuban American elders. Since this was the largest ethnically homogenous group the major analyses and results presented here are reported for this group. Separate analyses, however, are also reported for Samples 1 and 2 in order to attempt to assess the generalizability of the approach.

The sample of 66 Cuban American elders included 13 males and 53 females; average age was 67.2 (s.d. = 9.0). There was a wide spread in the time spent in the United States ranging from 3 months to 26 years, with a mean of 13.6 years and a standard deviation of 5.9 years. The overall education level of the sample was relatively low with a mean of 8.3 years of education (s.d. = 4.7). Fully 67% of this sample had never gone beyond elementary school and 75% never finished high school. In terms of their acculturation to life in the United States, the group presented a picture of very strong ties to their native Cuban culture. The mean score on the Behavioral Acculturation Scale (Szapocznik, Scopette, Kurtines and Aranalde, 1978) was extremely low ($\bar{x}$ = 34.0, s.d. = 14.5).

Measures

Dependent Variable. Two sets of measures of functioning were administered pre- and post-therapy. The pre-therapy evaluation was accomplished by the therapist while the post-therapy evaluation was accomplished by a therapist from the same unit who had not been associated with the case. The measures were:

1. The CARS Multidimensional Functional Assessment Questionnaire

(Pfeiffer, 1975) which was used to measure the degree of impairment in the areas of social resource, economic resources, mental health, physical health, and activities of daily living.

2. The Subjective Distress Macroscale of the Psychiatric Status Schedule (PSS; Spitzer, et. al., 1970) provided two scales measuring symptoms of subjective distress. These were depression-anxiety, daily routine-leisure time impairment, social isolation, suicide-self-mutilation, and somatic concerns.

Translation of both of these measures into Spanish was accomplished through the method of back translation (Brislin, 1970)

Because it is desirable to obtain outcome assessments that reflect various perspectives (Waskow and Parloff, 1974) in addition to the standardized outcome measures, a global rating of improvement was obtained from the counselors. The counselors' rating were made at the time of termination. The ratings ranged as follows: 1 = worse, 2 = no change, 3 = slight improvement, 4 = considerable improvement and 5 = best outcome.

Independent Variables. The following variables were used as independent variables in the data analyses:

1. Behavioral Acculturation Scale (Szapocznik, Scopetta, Kurtines and Aranalde, 1978c). This scale is a 24 item factorally derived instrument designed to measure individual language usage, customs, habits, and preferred idealized lifestyle. Szapocznik, et. al. (1978c) report high levels of reliability (internal consistency, retest and parallel forms), and evidence has been obtained for contruct validity (cf. Kurtines and Miranda, in press).

2. Extent of life enhancement counseling. Whereas all the cases reported

in the analysis below were intended to receive life enhancement counseling, the degree to which life enhancement counseling was conducted, including emphasis on the special technique of this approach (described below), varied from individual to individual. To account for these between subject differences, ratings of the "extent of life enhancement counseling" were obtained. Each of the case histories were reviewed by four members of the professional staff who were not involved directly in the delivery of services. Each rater made an independent judgement using the following scale: 1 = slight life enhancement counseling, 2 = moderate life enhancement counseling, and 3 = excellent example of life enhancement model.

3. Medication. After an initial admissions interview, the counselor determined if a psychiatric evaluation was necessary. For those cases in which the psychiatric evaluation indicated it necessary, appropriate medication was prescribed. Medication was regularly monitored by the staff psychiatrist. The extent of medication for each client was scaled using the following values: 0 = no medication used, 1 = some medication used, 2 = medication used throughout treatment.

4. Total number of sessions. The total number of sessions refers to all sessions with the counselor and/or psychiatrist, including admission and evaluation as well as treatment sessions.

5. Demographic information. This included age, sex, number of months of residence in the United States, and education.

Treatment

A brief discussion of Life Enhancement Counseling is presented below. For more detailed theoretical and clinical discussions of life enhancement

counseling, the reader is referred to Szapocznik, et. al. (in press) and to Manual (1980),[1] respectively. The life enhancement counseling model consisted of two major techniques designed to enhance the meaningfulness of life of elderly persons: life review, and ecological assessment and intervention.

Life Review. The life review procedure involved having an elder recount his or here life events and experiences. This life review procedure used standard interviewing techniques and clinical methods to elicit reminiscences in elders. The procedure was administered flexibly and in such a fashion that the counselor encouraged a general recounting by the elder of his/her life experiences. Life review, in the form of recounting life experiences, has been widely used as a therapeutic tool in mental health treatment with the elderly (e.g. Butler, 1961), and is considered an effective therapeutic technique in itself: it has cathartic value because it allows expressions of fears, frustrations and misgivings, and it also facilitates achievement of ego integrity by helping to organize memories in a way that brings closure to these experiences. However, as utilized in Life Enhancement Counseling, life review was extended beyond the simple recounting of life experiences. It incorporated three additional strategies: (1) enhancing meaningfulness of positive memories, (2) facilitating acceptance of unresolved incidents which interfere with ego integration, and (3) re-discovery of past strengths, capabilities or interests that can be re-enacted in subsequent phases of the treatment program (explained below).

(1) Enhancing meaningfulness of positive memories was accomplished during life review by identifying events, incidents, relationships or periods in the elder's life that were filled with meaning and raison d'etre. Once

[1] A copy of the manual can be obtained from the senior author.

these significantly meaningful aspects of life were identified, these was an effort to expand them and to gain clarity on them. Clinical techniques were used, as appropriate, "to bring to life" these meaningful life segments, creating a here and now experience around them. This strategy was particularly useful in the initial stages of treatment with the depressed elder. The purpose of this strategy was to provide a positive experience during the initial therapy sessions, a state which was incompatible with depressed feelings, and which provided a sense of immediate therapeutic gain.

(2) Facilitating acceptance of unresolved incidents which interfere with ego integration was another strategy used during life review. For many despairing elderly persons, the meaningfulness of their past history was stored behind a was of unresolved negative feelings. In these cases, clinical techniques were emplyed to facilitate acceptance of these feelings and events in order to achieve ego integrity. For this purpose, a number of clinical techniques were found helpful, including gestalt, and psychodynamic methods. Particularly useful in working with this population was a technique termed directive reinterpretation (cf. Manual, 1980). Directive reinterpretation refers to providing the elder with an alternative interpretation to events or experiences that helps to move the patient toward some therapeutic goal. When used as part of life review, the therapeutic goal is the acceptance of past events or experiences.

(3) Finally, re-discovery of past strengths, capabilities or interests that could be re-enacted as part of the treatment program was a third strategy within life review. The emphasis of this strategy was to identify themes that ran through the elder's history that provided them with meaning and

purpose throughout their lives. During the course of the life review, the counselor listened for features of these experiences that reflected each elder's values and definition of meaning in life. Later the counselor using ecological interventions attempted to re-enact meaningful experiences in the present, with meaning defined uniquely by each elder through the life review. Work with the clients in the research project discussed here has taught the authors that themes ameanable to re-enactment are varied and may have had lesser or greater centrality in elders' lives.

Ecological Assessment and Intervention. The ecological approach (Auerswald, 1971) is derived from systems theory which emphasized the interaction between the individual and the extrapersonal environment. An ecological approach conceives the problem of meaninglessness as rooted in the patterns of transaction between elders and their environment. The approach assumes that the person and the environment share the responsibility for the initiation and maintenance of the transactions that occur between them. Thus, in the ecological model of services delivery, the focus is neither on changing the person nor the environment: rather, the focus is on changing the transactions betweenthe person and the environment. In the case of elders, the intended direction of change is from less to more meaningful and fulfilling transactions. The ecological work of Life Enhancement Counseling can be explained in two parts: (1) assessment and (2) intervention. In practice, these parts were closely interrelated and they occurred throughout the entire treatment process.

(1) Following or concurrent with the life review process, an assessment of the elder's ecological situation was conducted. Its purpose was two fold:

to identify environmental sources of stress and to identify the resources that were available to each elder with the objective of ascertaining the ecological possibilities of effecting current life experiences that were meaningful. The determination of what was meaningful was obtained in each case from the life review.

Within the Life Enhancement approach the scope of ecological assessment was limited to identifying those transactions which contributed to the elderly patients' current conditions and those resources which could facilitate an improved person-social environment. For this reason, the assessment did not dwell on intrapersonal or macrosocial condition, but on the interface between these as they affected the elderly patients' conditions. The ecological assessment was focused in that it was designed to be intimately liked with the nature of the preseting problem, yield specific treatment goals and a sense of how to achieve them, and limited to understanding the nature and source of the transactions that sustained and could change the presenting problem without probing unnecessarily into intrapersonal or macrosocial dynamics.

(2) Ecological intervention can be conceptualized in terms of three phases: testing the viability of the identified resources, developing an ecological treatment plan, and restructuring. Concurrent with the ecological assessment, as resources were identified, the counselor began to test the viability of identified resources. In this case, testing refers to determining flexibility or rigidity of existing transactional patterns between the patient and the resources identified as potential support systems. Once one or more potential directions for changing transactions were identified, the counselor developed an ecological treatment plan to restructure the patient-environmental transactions. The development of a treatment plan was closely interrelated with the

previous and the following phase in the sense that testing, planning, and restructuring were all part of an ongoing process. The entire process required the use of considerable clinical skill because each step toward changes in patient-environmental transactions involved a test of flexibility in the direction of change that had to be incorporated into a treatment plan that was developed on the march as each test for flexibility was passed. The successful restructuring of patient-environment transactions represented the ecological intervention process. The underlying assumption of the ecological intervention was that changes in transactions could take place; the testing, planning and restructuring process was aimed at identifying and implementing appropriate interventions that would result in the desired changes for each individual client.

Counselors

Three Cuban American counselors conducted the life enhancement counseling procedures. These counselors were bilingual and bicultural. There were two men and one woman. Their levels of training varied to include one bachelors degree in social work, one masters degree in social work and one doctorate in counseling psychology. Their clinical experience was also varied ranging from two to 15 years of clinical experience. The counseling supervisor was a biligual bicultural individual with a masters degree in social work with extensive clinical experience and in directing demonstration clinical services.

RESULTS

Two main sets of analyses will be reported in this section: (1) pre-post analyses on the outcome measures, and (2) regression analyses to determine parameters of treatment effectiveness.

Outcome Analyses

The data on the outcome measures for the elders were analyzed as follows. Two tailed t-tests for paired samples were calculated to compare the mean pre and post scores on the variables derived from the OARS and the PSS. The means,

standard deviations, and levels of significance for the pre-post scores are presented in Table 1.

Insert Table 1 about here

As Table 1 depicts, mean post-test scores for the total sample and Cuban elders for all OARS variables were significantly lowered, reflecting significant improvements in the multiple dimensions of functioning assessed by this instrument. While significant reductions occurred for all variables, the most dramatic improvement is not in any one area but in overall functioning as assessed by OARS total score. The differences for the OARS total yielded the largest t-values for both the total sample, $t(99) = 14.23$, $p < .001$ and for Sample 3, the Cuban elders, $t(65) = 11.63$, $p < .001$. The largest improvement for a single scale, was predicatably mental health, $t(99) = 9.94$, $p < .001$, and $t(65) = 8.48$, $p < .001$, respectively.

Analyses of the data obtained from Sample 2, the non-Cuban elders (comprised of 9 non-Cuban Hispanics and 6 non-Hispanic Aglos), provide some tentative evidence for the generalizability of Life Enhancement Counseling as an effective intervention modality with non-Cuban elders. The pre-post differences on overall OARS and the total PSS Subjective Distress were significant for Sample 2, reflecting the effectiveness of Life Enhancement Counseling with this group. However, for this sample, not all of the individual scales reflected significant improvement. The improvements were greatest in OARS-Mental and Physical Health and in PSS-Depression Anxiety and not significant in OARS-Social Resources and Activities of Daily Living. Hence, the greatest improvement for this group took place in the mental health area and the least improvement in daily routine and social resources.

In order to assess the impact of treatment intervention (support and environmental manipulation) received by the group of individuals judged inappropriate for Life Enhancement Counseling, Sample 1, outcome analyses were also conducted for this sample (N = 19). Generally, this group did not appear to differ from the other groups in terms of the client characteristics examined such as age and sex. However, this group was generally more impaired at the time of admission and termination. At admission they were significantly more impaired on OARS Physical Health, $F(2,97) = 3.67$, p .05, and OARS Activities of Daily Living, $F(2,97) = 3.09$, p .05. An ANCOVA of the post test scores comparing Sample 1 with Samples 2 and 3 combined, used pre tests as a covariate. This analysis yielded a significant difference between groups on OARS Physical Health, $F(2,96) = 4.84$, p .01.; OARS Mental Health, $F(2,96 = 3.11$, p .05; and OARS Economic Resources, $F(2,96 = 8.10$, p ..001, indicating that Sample 1 improved less than Samples 2 and 3 combined.

Predication of Differential Success

Analyses were performed which were aimed at identifying variables that were predictive of differential overall success in Life Enhancement Counseling. In order to achieve this goal it was necessary to conduct an analysis of the outcome criteria structure and to develop a composite measure of treatment effectiveness. Three sets of variables were used in these analyses. The therapists' global clinical rating of improvement was the first variable used. Pre and post test scores on the OARS total scale and the PSS Subjective Distress macroscale were the others. There were two steps in the development of the composite treatment effectiveness measure. The first step involved using regression techniques to estimate how much of the post test score variance for

OARS total and Subjective Distress was due to pre-test standing. The results of the regression analyses were used to calculate predicted post scores. The difference between the actual and the predicated scores constituted a "Residualized gain" score (Cascio and Kurtines, 1975; Luborsky, Mintz and Christoph, 1979). This procedure extracted from the test score that variability due to pre test scores. The remaining or residual variance was considered to be an appropriate measure of treatment gain. Once residual gain scores had been calculated for the OARS total scale and the PSS Subjective Distress scale, then factor analytic techniques were used to analyze the structure of the outcome criteria and to develop a single composite measure of treatment effectiveness. The outcome criteria included the two sets of residualized gain scores (OARS,PSS) and the counselor's clinial global ratings of improvement.

The three treatment effectiveness measures were factor analyzed using a principal components solution and varimax rotation. The principal component solution yielded two factors with eigenvalues greater than 1. The first factor accounted for 49.4% of the total variance and the second factor accounted for 33.4% of the total variance. The two principal component factors were rotated using a varimax rotation. The first rotated factor accounted for 84.5% of the common factor variance and the second rotated factor accounted for 15.5% of the common variance. Since the first rotated factor accounted for nearly 85% of the common variance, it was used to construct a composite measure of treatment effectiveness. The loadings for the variables on this factor (hereafter referred to as the Treatment Effectiveness Composite Factor) were: OARS gain, .09; PSS gain, .03; Clinical Global Rating, .70. As

these loadings reveal, most of the variance on the Treatment Effectiveness Composite Factor was accounted for the OARS Gain and the Clinical Global Ratings, with PSS Gain not achieving significant loading on this factor. Because PSS Gain was the only variable with a loading in excess of .30 (OARS Gain, .25; PSS Gain, .36; Clinical Global Rating, -.07) on the second factor, it was used as a second dependent variable in subsequent analyses.

A stepwise multiple regression analysis was conducted using the Treatment Effectiveness Composite Factor as the dependent variable, and acculturation, age, sex, number of months in the United States, and education as independent variables. The results of this regression analysis indicated that none of these client variables were significant predictors of improvement as measured by this factor. A second regression analysis was conducted, this time using Subjective Distress Gain as a dependent variable. Again the results of this analysis were nonsignificant.

A stepwise multiple regression analysis was conducted using the Treatment Effectiveness Composite Factor as the dependent variable, and extent of life enhancement counseling, medication and total number of sessions as predictor variables. The results of this analysis indicated that the single significant predictor of the Composite Factor or Factor 1 was the extent of life enhancement counseling, $F(1,60)^* = 18.14$, $p < .001$. A final regression analysis was conducted using Subjective Distress Gain (representing Factor 2) as the dependent variable. The results of this analysis indicated that the single significant predictor of improvement on this scale was medication, $F(1,60 = 6.18$, $p < .05$.

The regression analyses of the effect of treatment variables upon outcome

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* four subjects were deleted from the analysis because of missing data

revealed that extent of life enhancement counseling was the best predictor of composite gain (based on OARS gain and clinical improvement ratings) while the use of medication was the best predictor of improvements in levels of subjective distress. Note, however, that whereas composite gain accounted for 85% of the variance, Subjective Distress gain accounted for only 15% of the total variance. These findings would suggest that within the Life Enhancement Counseling Model, these two treatment variables have differential effects on different types of problems. Life enhancement impacts on multidimensional functioning, where most of the improvement takes place, while medication relieves subjective distress which accounts for a small portion of the improvement. The overall results of the regression analses thus revealed that none of the client variables were predictive of differential success, but that two of the treatment variables were. In view of this finding, further analyses were conducted to examine in closer detail the effects of these treatment variables on outcome measures.

The first set of anlyses was designed to determine whether life enhancement was also effective in reducing subjective distress in those clients who received no medication. From the total sample of 66 Cuban elders, 23 received no medication. For these 23 subjects, analyses conducted on pre-post test scores of subjective distress revealed a significant improvement in total Subjective Distress Macroscales, $t(22) = 4.06$, $p < .001$. Depression-Anxiety decreased significantly ($t(22) = 4.40$, $p < .001$.), as did Social Isolation ($t(22) = 2.10$, $p < .05$). Somatic Concerns and Suicide/Self-Mutilation did not improve significantly. However, an examination of the pre-post means for Somatic Concerns and Suicide/Self-Mutilation indicated that the lack of

apparent improvement was a result of very low initial scores which were already close to the "floor" in both of these scales. Thus, although medication was the best predictor of improvement in subjective distress, clients who received no medication but received life enhancement counseling improved on subjective distress total scores and on three subscales.

The second set of analyses examined in detail the effects of the two treatment variables, life enhancement counseling and medication, on the principal outcome measures. Two 2 x 2 analyses of covariance were conducted separately on post OARS total and PSS Subjective Distress Total with pretest scores as covariates. The independent variables for these analyses were (1) low vs. high levels of life enhancement counseling and (2) medication vs. no medication. For the OARS variable, there was a significant effect for level of life enhancement, $F(1,61) = 3.28$, p .08 (see Figure 1). For the PSS variable, there was a significant effect for medication, $F(1,61) = 5.77$, p .02 (see Figure 2).

Insert Figures 1 and 2 about here

Discussion

The research reported in this article was intended to assess the effectiveness of an innovative integration of treatment strategies for providing mental health services to elders. The results of the study have several methodological, conceptual, and clinical implications for development and evaluation of treatment approaches for use with the elderly. With regard to research methodology, the most significant finding concerned the differential utility of the outcome measures. The OARS Multidimensional Functional Assessment Questionnaire proved effective in all the analyses, while the PSS,

which was designed for use with inpatient populations, displayed a distinct floor effect for post test evaluation when used with this outpatient population. This finding demonstrates the need for the use of multiple outcome measures as well as measures designed for use with the appropriate target population. A second important methodological finding concerned the use of extent of therapeutic intervention as a predictor variable in the differential outcome analyses. The quantification of degree of intervention is particularly important for treatment research. In the case of the elders in this study, to more precisely assess the effectiveness of Life Enhancement Counseling it was necessary to quantify the extent to which Life Enhancement Counseling was actually provided to each elder, thereby controlling for the effects of between subject variability due to differences in the level of the desired intervention, Life Enhancement Counseling.

The results of the research reported here have some significant implications for conceptualizing mental health services for the elderly. First, the findings provide support for the validity of conceptualizing many of the psychological difficulties and "disorders" of elders as potentially reversible rather than inevitable consequences of the aging process. Perhaps more importantly, the findings indicate that in many cases the difficulties were amenable to psychosocial intervention both with and without pharmacotherapy. Thus, not only did those elders who received no medication improve, there was also a significant reduction by extent of Life Enhancement Counseling interaction, indicating that those clients who received both medication and Life Enhancement Counseling did better than those who received mediction or Life Enhancement Counseling alone.

Second, the findings have implications for the conceptualization and development of treatment strategies that are matched to client characteristics. As the overall results indicated, it was possible to develop an effective treatment model for counseling Hispanic elders that was sensitive to both age and cultural characteristics. This model draws on elders' strengths such as knowledge and life experience as well as natural proclivities such as the tendency to reminisce while delivering services in a manner to which they are culturally accustomed.

The work reported in this paper has important clinical implications. The most clinically relevant findings can be summarized as follows:

First, Life Enhancement Counseling proved to be an effective method in the treatment of depressed elders, particularly those who had lost their sense of meaning and purpose in life. Second, Life Enhancement Counseling was effective with a wide variety of elders across age, sex, socioeconomic status, education, acculturation levels and ethnic background. Third, Life Enhancement Counseling was particularly effective in bringing about multidimensional improvement in the areas of social resources, economic resources, mental health, physical health and activities of daily living. Fourth, Life Enhancement Counseling by itself (i.e., without medication) was effective in reducing subjective distress, particularly depression/anxiety in those clients presenting initially moderate levels of dysfunction. Finally, the results indicate that Life Enhancement Counseling should be used in conjunction with anti-depressant medication with clients who present severe levels of subjective distress. With these clients, the medication was effective in reducing subjective distress, although Life Enhancement Counseling had a substantial effect beyond

that of the medication alone.

The Life Enhancement Counseling Model described in this paper represents an innovative integration of treatment strategies for providing mental health services to elders. This approach utilizes elders' natural proclivity to reminisce and recognizes the significance of their current ecological conditions. Life Enhancement Counseling thus draws on elders' past strengths and competencies, and re-enacts these in the present in an effort to ameliorate those conditions that contribute to elders' mental health distress. The development of this method is rooted in a philosophic orientation to service delivery that encourages tailoring treatment to client characteristics and needs, rather than forcing clients into existing treatment models.

TABLE 1

Means and Standard Deviations Before and After Therapy for Subjects on Measures

	Cuban Elders n=66		Non-Cuban Elders n=15		Inappropriate n=19		Total Sample n=100	
	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
OARS Total	14.29(2.98)	11.17(2.80)c	14.40(2.95)	10.87(2.53)c	17.42(3.66)	15.00(3.70)c	14.90(3.31)	11.85(3.30)c
Social Resources	2.86(0.96)	2.32(0.95)c	3.00(1.00)	2.40(0.99)	3.37(1.07)	3.05(0.85)a	2.98(1.00)	2.47(0.97)c
Economic Resources	3.2[illegible](0.91)	2.38(0.80)c	3.40(1.24)	2.47(0.73)a	3.74(1.20)	3.00(0.75)b	3.35(1.[illegible])	2.51(0.81)c
Mental Health	3.17(0.69)	2.36(0.60)c	3.07(0.59)	2.20(0.41)a	3.53(1.17)	2.84(1.01)b	3.22(0.80)	2.43(0.70)c
Physical Health	2.67(0.90)	2.29(0.82)c	2.73(0.96)	2.13(0.74)b	3.47(1.07)	3.21(1.32)	2.83(0.99)	2.02(1.21)c
Activities of Daily Living	2.36(1.18)	1.82(1.01)c	2.20(0.86)	1.80(1.01)	3.26(1.41)	2.89(1.60)	2.51(1.23)	2.02(1.21)c
PSS Subjective Distress	53.21(17.50)	34.29(5.20)c	53.13(11.86)	36.47(8.81)c	47.10(15.89)	36.63(9.79)b	52.04(16.51)	35.06(6.88)c
Depression-Anxiety	53.82(14.70)	34.62(6.91)c	54.53(11.60)	37.60(10.66)c	46.47(13.71)	36.00(9.70)b	52.53(14.28)	35.33(8.11)c
Daily Routine/Leisure Time Impairment	50.11(14.22)	38.94(3.92)c	48.20(9.98)	40.87(8.89)a	46.53(13.94)	40.84(6.99)	49.14(13.58)	39.59(5.57)c
Social Isolation	49.70(13.64)	40.00(2.96)c	51.53(12.69)	40.67(3.74)b	51.00(15.51)	41.58(3.57)a	50.22(13.76)	40.40(4.63)c
Suicide/Self-Mutilation	47.00(8.39)	42.45(2.43)c	46.40(7.34)	41.93(0.26)a	43.89(4.92)	42.32(1.38)	46.32(7.73)	42.35(2.06)c
Somatic Concern	56.20(21.32)	44.83(4.61)c	53.00(12.42)	44.27(1.03)a	52.95(15.77)	48.21(6.93)	55.10(19.18)	45.39(4.97)c

Note: Post test scores with subscripts denote significance pre-post levels as follows: a = p .05; b = p .01; c = p .001

Figure 1

OARS TOTAL SCORE AS A FUNCTION
OF TESTING TIME AND TREATMENT

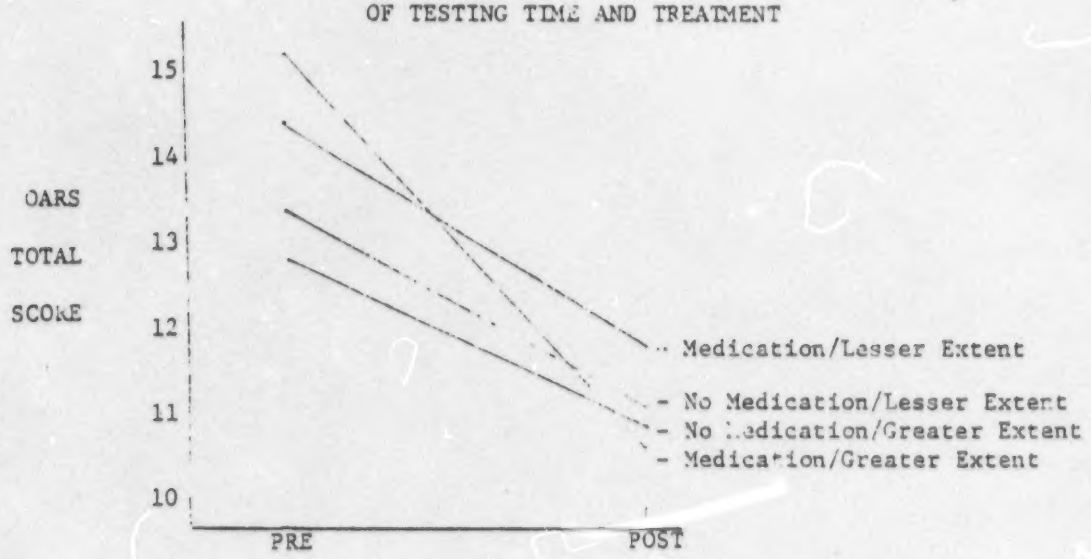
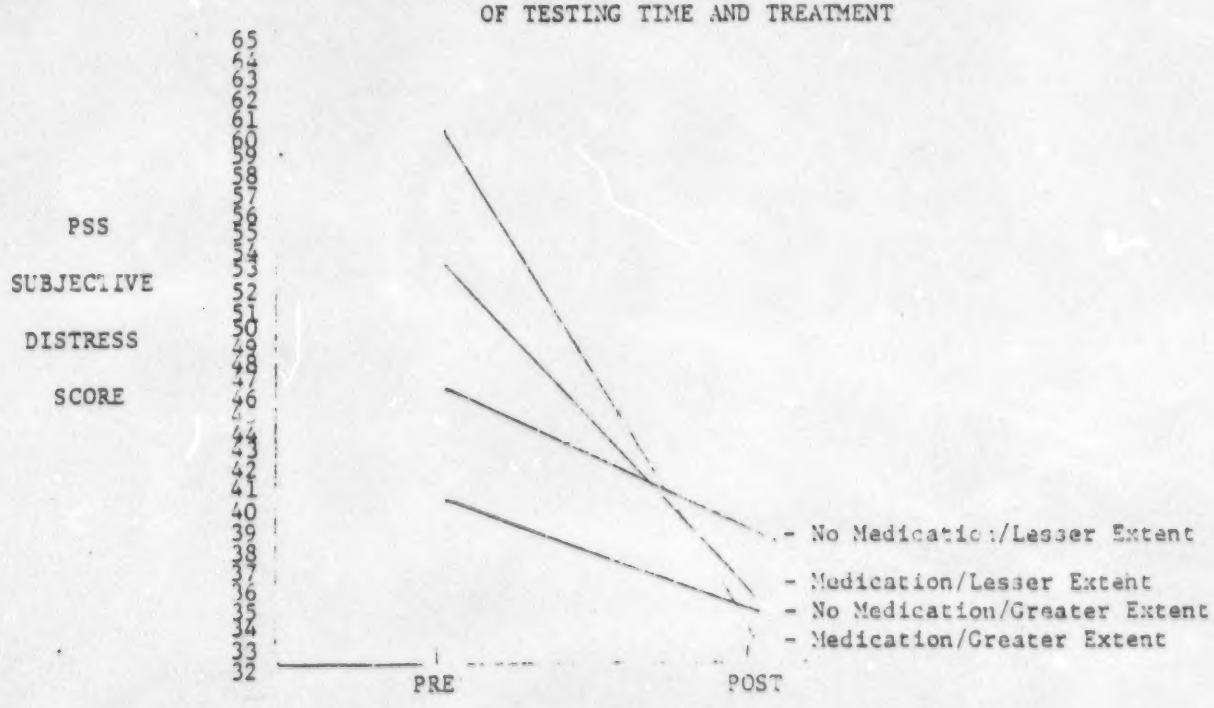


Figure 2

PSS SUBJECTIVE DISTRESS AS A FUNCTION
OF TESTING TIME AND TREATMENT



REFERENCES

Auerswald, E.H. Families, change, and the ecological perspective. Family Process, 1971, 10, 263-280.

Ban, T. A. The treatment of depressed geriatric patients. American Journal of Psychotherapy, 1978, 32, 93-104.

Bergin, A. E. The evaluation of therapeutic outcomes. In A. E. Bergin and S.L. Garfield (Eds.), Handbook of psychotherapy and behavior change. New York: John Wiley & Sons, 1971.

Breslin, R.W. Back-translation for cross-cultural research. Journal of Cross-Cultural Psychology, 1970, 1, 185-216.

Butler, R.N. Re-awakening interests. Nursing Homes: Journal of American Nursing Home Association, 1961, 10, 8-19.

Carter, R. Opening Address, National Conference on Mental Health and the Elderly, Select Committee on Aging, Washington, D. C., April 23 & 24, 1979.

Cascio, W. and Kurtines, W., A practical method for identifying significant change scores. Educational and Psychological Measurement, 1977, 37, 889-896.

Cohen, G. Report to the National Conference on Mental Health and the Elderly, Select Committee on Aging, Washington, D. C., April 23 & 24, 1979

Erickson, E.H. Childhood and Society, New York: Norton, 1950.

Goin, M., Yamamoto, J., and Silverman, J. Therapy congruent with class-linked expectations. Archives of General Psychiatry, 1965, 13, 133-137.

Gould, R. E. Dr. Strangeclass: Or how I stopped worrying about the theory and began treating the blue-collar worker. American Journal of Orthopsychiatry, 1967, 37, 78-86.

Heitler, J. B. Preparatory techniques in initiating expressive psychotherapy with lower-class, unsophisticated patients. Psychological Bulletin, 1976, 83 (2), 339-352.

Hunt, R. G. Social class and mental illness: Some implications for clinical theory and practice. American Journal of Psychiatry, 1960, 116, 1065.

Jarvik, L. F. Aging and depression: Some unanswered questions. Journal of Gerontology, 1976, 31, 324-326.

Kiesler, D. J. Experimental designs in psychotherapy research. In A. E. Bergin and S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change. New York: John Wiley & Sons, 1971.

Kluckhohn, F. R. & Strodbeck, F. L. Variations in value orientations. Evanston, Illinois: Row, Peterson & Co., 1961.

Kramer, M., Taube, C. and Starr, S. Patterns of Use of Psychiatric Facilities by the Aged: Current Status, Trends and Implications. In Aging in Modern Society, Simon A. and Epstein, L. J., Eds. Psychiatric Research Report No. 23, American Psychiatric Association, New York 1968.

Kurtines, W., and Miranda, L. Family role perception among acculturating Cuban American college students. International Journal of Intercultural Relations, in press.

Lewis, M. & Butler, R. Life-review therapy: Putting memories to work in individual and group psychotherapy. Geriatrics, November, 1974, 165-173.

Lerner, B. Therapy in the ghetto: Political impotence and personal desintegration. Baltimore, MD: John Hopkins Press, 1972.

Lorion, R. P. Patient and therapist variables in the treatment of low-income patients. Psychological Bulletin, 1974, 81, 344-354.

Luborsky, L., Mintz, J., & Christoph, P. Are Psychotherapeutic Changes Predictable? Comparison of a Chicago Counseling Center Project With a Penn Psychotherapy Project. Journal of Consulting and Clinical Psychology, 1979, 47, 469-473.

Magaro, P. A prescription treatment model based upon social class and premorbid adjustment. Psychotherapy, 1969, 6, 57-70.

Orne, M., & Wender, P. Anticipatory socialization for psychotherapy: Method and rationale. American Journal of Psychiatry, 1968, 124, 88-98.

Paul, G. L. Behavior modification research: Design and tactics. In C. M. Franks (Ed.), Behavior Therapy: Appraisal and status. New York: McGraw-Hill, 1969.

Pfeiffer, E. OARS Multidimensional Functional Assessment Questionnaire. Duke University Center for the Study of Aging and Human Development, 1975.

Sloane, R. B., Staples, F. R., Cristol, A. H., Yorkston, N. Y., & Whipple, F. Patient characteristics and outcome in psychotherapy and behavior therapy. Journal of Consulting and Clinical Psychology, 1974, 44 (3), 330-339.

Spitzer, R. L., Endicott, J., Fleiss, J. L. & Cohen, J. The psychiatric status schedule: A technique for evaluating psychopathology and impairment in role functioning. Archieves of General Psychiatry, 1970, 23, 41-55.

Szapocznik, J. Life Enhancement Counseling Manual, Spanish Family Guidance Center, University of Miami, in preparation.

Szapocznik, J., Santisteban, D., Kurtines, W.M., Hervis, O.E., Spencer, F., Life Enhancement Counseling: A psychosocial model of services for Hispanic elders. In E.E. Jones and S.J. Korchin (Eds.), Minority Mental Health, New York: Holt, Rinehart and Winston, in press.

Szapocznik, J., Scopetta, M.A., & King, C.E. Theory and practice in matching treatment to the special characteristics and problems of Cuban immigrants. Journal of Community Psychology, 1978a, 6, 112-122.

Szapocznik J., Scopetta, M. A., Aranalde, M. A., & Kurtines, W. Cuban value structure: Treatment implications. Journal of Consulting and Clinical Psychology, 1978b, 46, 961-970.

Szapocznik, J., Scopetta, M. A., Kurtines, W. & Aranalde, A. Theory and measurement of acculturation. Interamerican Journal of Psychology, 1978c, 12, 113-130.

Terestman, N., Miller, J., & Weber, J. Blue-collar patients at a psychoanalytic clinic. American Journal of Psychiatry, 1974, 131, 261-266.

Waskow, I. E., & Parloff, M. B. Psychotherapy change measures, Report of the Clinical Research Branch (NIMH) Outcome Measures Project DHEW Publication No. (ADM) 74-120). Washington, D. C.: U. S. Government Printing Office, 1975.

Reference Notes

Manual: Life Enhancement Counseling. Spanish Family Guidance Center, University of Miami, Coral Gables, Florida, 1980.

Santisteban, D. Locus of control as a cross-cultural variable. Unpublished Masters Thesis, University of South Florida, Tampa, Florida, 1975.